

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATHState File No. **27665**

FILED SEP 8 1947

Registration District No. **149**Primary Registration District No. **1002**Registrar's No. **3660**

## 1. PLACE OF DEATH:

(a) County **Jackson**  
 (b) City or town **Kansas City**  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution **General Hospital No. 1**  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution **6 days**  
 (Specify whether years, months or days) **40 years**

3. (a) PRINT FULL NAME **Ida Eberhart**3. (b) If veteran,  
name was **no**3. (c) Social Security No.  
**none**

4. Sex **Female** 5. Color or race **white**  
 6. (a) Single, widowed, married, divorced **Widowed**  
 6. (b) Name of husband or wife **Seth Eberhart**  
 6. (c) Age of husband or wife if alive **6** years  
 7. Birth date of deceased **June 6 1947**  
 (Month) (Day) (Year)

8. AGE: Years **71** Months **2** Days **19**  
 If less than one day **hr. min.**

9. Birthplace **Parkville Mo.**  
 (City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

## 11. Industry or business:

12. Name **William Burns**  
 13. Birthplace **Louisville Kentucky**  
 (City, town, or county) (State or foreign country)  
 14. Maiden name **Sarah Staples**  
 15. Birthplace **Platte Mo.**  
 (City, town, or county) (State or foreign country)

16. (a) Informant **Miss May Eberhart**  
 (b) Address **4026 Woodland K.C. Mo**  
 17. (a) **Buried** (b) Date thereof **8-25-47**  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation **Mt. Moriah**

18. (a) Signature of funeral director **Harley Roe**  
 (b) Address **7406 Wornall K.C. Mo**  
 19. (a) **8-26-47** (b) **Estherline Holman**  
 (Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson**  
 (c) City or town **Kansas City**  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. **4026 Woodland**  
 (If rural, give location)  
 (e) Citizen of foreign country? **no** (Yes or No)  
 If yes, name country

## MEDICAL CERTIFICATION

**August 25th**

20. DATE OF DEATH: Month **August** day **25th**  
 year **1947** hour **9** minute **55** A.M.

21. I hereby certify that I attended the deceased from **8-19-47** to **8-25-47**  
 that I last saw him alive on **8-25-47**  
 and that death occurred on the date and hour stated above.

Immediate cause of death  
**Uremia**

Due to **Chronic glomerulo-nephritis**

Due to

Other conditions  
 (Include pregnancy within 3 months of death)

Major findings:  
 Of operations

Of autopsy  
**See above**

## 22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)  
 (b) Date of occurrence  
 (c) Where did injury occur?  
 (City or town) (County) (State)  
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?  
 (Specify type of place)  
 While at work? (e) Means of injury

23. Signature **Wm W. Hart** (M. D. or other)  
 Address **Med. Dir. K.C. Gen. Hospital** Date signed

## PHYSICIAN

Underline the cause of which death should be charged statistically.

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by \_\_\_\_\_

\_\_\_\_\_, Registered Apprentice No. \_\_\_\_\_  
working under my personal supervision.

Signed \_\_\_\_\_

*J. Royce Koger*

Licensed Embalmer No. *3579*

P. O. Address *Overland Park, Kans.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.